STATEWIDE PROGRAM STANDING COMMITTEE
FOR ADULT MENTAL HEALTH

April 14, 2008
Notes

MEMBERS PRESENT: Lise Ewald, Kitty Gallagher, George Karabakakis, Clare Munat, Marty Roberts, and Jim Walsh

VISITORS: Michael Fitzgerald, Jean New, and Grace Zdunek

DMH STAFF: Wendy Beinner, Michael Hartman, Melinda Murtaugh, Michelle Lavallee, Frank Reed, Terry Rowe, Tom Simpatico, and Evan Smith

Clare Munat facilitated today's meeting. Standing Committee members and visitors introduced themselves. Approval of the notes for the meetings of February 11 and March 10 as submitted was unanimous.

Vermont State Hospital (VSH): Terry Rowe

VSH Policies. Terry began her report by talking about some of the policies at VSH: one defining staff-patient relationships (therapeutic relationships only), the policy on visitors, and another one on patient work. There are no problems with inappropriate staff-patient relationships, Terry said; this policy is basically a reminder to everyone concerned. The policy on visitors and visiting hours is intended to balance the State Hospital's responsibility to provide twenty therapeutic hours for patients each week with the patients' and visitors' desires to see each other. VSH will do what it can to make accommodations for unusual circumstances (for example, someone who has to travel a great distance to get to Waterbury). Jim Walsh remarked that the VSH policy on visits is similar to the policy at the Windham Center.

The patient work policy is a result of VSH's desire to have one; it is also a requirement of the Joint Commission. Hospital staff are currently looking at a vocational training program. Clare Munat asked for an example of Procedure No. 8: "The treatment team may suspend or terminate the placement for failure to comply with treatment program rules and/or clinical considerations related to the individual treatment plan." Terry said it could apply to a patient who does not carry out job duties as assigned. The work policy is still in draft form, Terry added. Michael Fitzgerald asked about the possibility of education if patients want to study something. Developing an education component is still in the future, Terry said, but is certainly worth considering. Jean New asked about consumer and ex-patient involvement. Terry told Standing Committee members that she endorses peer involvement. In response to a question from Clare about reasonable accommodations, Terry said that it is possible to add language to the policy indicating that VSH will comply with the requirements of the Americans with Disabilities Act.

Visit from Rutland Regional Medical Center (RRMH). RRMH leadership paid a visit to VSH last week out of preliminary interest in treating patients with levels of need very like VSH

patients. They toured the State Hospital and met with many VSH staff, Terry said. VSH is willing to do anything that is possible to help RRMC be successful.

Joint Commission Visit. VSH is still waiting for the Joint Commission's site visit.

Recertification. Terry has written the Centers for Medicare and Medicaid Services to state VSH's intent to apply for recertification. In general, VSH staff are optimistic now, Terry said.

Next Visits from the Department of Justice (DOJ). Follow-up visits are scheduled in October 2008 and March 2009, according to Terry. The State Hospital is still waiting for the report from the last DOJ visit, in March.

Report on Transportation of Individuals in the Custody of the Commissioner of Mental Health: Michelle Lavallee

Michelle gave Standing Committee members a few minutes to review the report before discussing it. The time frame for the report is different from last year's; the 2008 report includes December 1, 2006-November 30, 2007.

Kitty Gallagher observed that no transportation in Rutland County occurred outside sheriffs' vehicles. Michelle described the alternate transport that is available in Washington and Chittenden counties. New this year, she added, is the use of polyurethane cuffs by three sheriffs, and that information will appear in next year's report. Also noteworthy is the fact that six sheriffs used no restraints in some cases.

Jean wondered asked about the possible use of unmarked cars. Frank Reed informed the Standing Committee that some of the funding for transportation in Washington and Chittenden counties included money for unmarked cars, and DAs there have used them. Other topics of discussion included:

- An addition to next year's report: data on types of restraints used
- Allowing parents to accompany children if at all possible
- Use of chemical restraints: no, unless required for treatment
- Ambulances as among the alternatives to sheriffs' vehicles
- Non-secure transports: two people in a van
- Polyurethane cuffs furnished by DMH—and sheriffs are showing a willingness to use them
- 91% of transports to the Vermont State Hospital (VSH) were non-secure

Re-designation of Counseling Services of Addison County (CSAC)

Evan Smith walked Standing Committee members through the re-designation materials for CSAC. Page 9 of the Clinical Care and Minimum Standards Review for the Community Rehabilitation and Treatment (CRT) program noted two requirements, one in regard to assessments and reassessments and another in regard to completion of information on all five

diagnosis axes. Under recommendations, DMH suggested greater attention to several components of assessments and reassessments (education, employment, cultural and ethnic influences, spiritual resources, and treatment recommendations). Standing Committee members discussed the importance of cultural and ethnic influences. Another concern under recommendations had to do with the reinterpretation of clients' goals into clinical language. It is a concern not unique to CSAC, Evan added. The reinterpretation is important for retaining reimbursable funding from the Centers for Medicare and Medicaid Services (CMS).

Finally, a requirement under Psychiatric Practice Standards noted the need for monitoring an individual's reaction(s) both physically and mentally to psychiatric medication. A recommendation noted that allergies should be prominently positioned in the client record. The agency has already proposed plans of improvement to address requirements.

In going through the Program Review Report, Evan remarked on DMH's overall satisfaction with CSAC's performance since its last program review two years ago. The review team made only one recommendation, this in regard to the Adult Outpatient program (AOP): lowering the waiting list for services (page 8 of the report). There were no requirements under any of the four quality domains around which the report is organized.

On accessibility requirements under the Americans with Disabilities Act (ADA): None of the sites where mental-health services are delivered were deficient in accessibility.

Clare asked about the client advocacy position mentioned on page 3. Marty said that she knows the person who first held the job and, as far as she knows, the duties of the position were not necessarily peer advocacy. Kitty mentioned that she has been working with CSAC peers and so has Vermont Psychiatric Survivors (VPS). She would like to see more work opportunities for peers away from the agency, she added. She also questions the agency's recovery orientation and how fully the clients understand recovery. Standing Committee members and guests present discussed the importance of recovery for clients and recovery orientation of agencies and staff. Marty told members that CSAC has a marvelous Recovery Educator now at Evergreen. Marty thinks that the agency is improving a lot.

Clare mentioned another concern: the AOP waiting list. It is important to get people well and let them move on so others can get services, she said. Clare asked who does screening for adult outpatients. Evan replied that Crisis Services does some assessments, and the agency does have a process to identify adults with higher levels of acuity.

Evan mentioned an additional problem area: access to psychiatry. But psychiatric services are a problem in other parts of the state too. On another subject, Evan said that the agency has done a very good job of implementing integrated treatment for clients with dual diagnoses of mental illness and substance abuse.

Clare directed Standing Committee members' attention to page 4 of the Program Review Report, on Hill House. Kitty has the impression that clients who live at Hill House think that they do not have enough to say about the house rules there. George Karabakakis told the Standing Committee that the walk-in program at Health Care and Rehabilitation Services of Southeastern Vermont (HCRS) has been very successful in reducing the waiting list for AOP.

Evan said that CSAC staff emphasized the agency's outreach to the community. Jean New talked about the need for more public education to reduce stigma. Clare wanted to know if CSAC is planning to expand training for integrated treatment. Evan said that CSAC was somewhat slow getting started but is now doing better on training. DMH will be watching developments, he concluded.

Evan remarked on how impressive CSAC's employment placements are: They are numerous in addition to giving clients a wide variety of jobs to choose from. CSAC Executive Director Bob Thorn gives the agency's Supported Employment program credit for having helped broaden minds in the business community in Middlebury.

Melinda Murtaugh will invite staff from CSAC to attend the Standing Committee's May meeting. Some of the questions and issues posed for discussion then are:

1. How is the concept of recovery integrated into what staff do at CSAC?
2. What are some examples of program successes/accomplishments that the agency would like to brag about?
3. Access to the Adult Outpatient Program
4. What is client turnover? Why to clients leave programs? (These questions apply to both CRT and AOP.) Does the agency keep track of adults on the AOP waiting list who do not make it into the program? For what reasons do they not make it into the program?
5. How is Crisis Services responding to recommendations and requirements in regard to the waiting list?
6. What is the job description for the consumer advocate position?
7. What is the training schedule for integrated treatment for dual diagnoses?
8. More information about the agency's efforts to become known in the community

Public Comment

Grace Zdunek wanted to know more about how the Standing Committee does its work, and Clare responded with relevant information.

Patient Advisory Council Meeting: Kitty Gallagher

Kitty has attended two meetings of the Patient Advisory Council. Four patients were at one meeting, three at the other. Kitty was expecting a group that would be more interested in looking at VSH rules, policy, and other matters, she said, but so far the Council has focussed on ways to get books out of the public library in Waterbury. There is no set membership, and Kitty thinks that there should be to develop leadership. Overall, she summed up, the Council is doing well enough for a newly formed group. It is important to empower clients to speak up for themselves.

Report from DMH Commissioner: Michael Hartman and Wendy Beinner

The Futures Project. Michael reported that the Futures Project continues to move ahead in two important areas: (1) DMH has received two proposals for a second recovery residence, one from Collaborative Solutions and one from Retreat Healthcare in Brattleboro in alliance with HCRS. (2) DMH is continuing its work with Rutland Regional Medical Center and Retreat Healthcare on developing inpatient capacity.

Potential Changes in the Implementation of Act 114. The General Assembly did not act on DMH's proposal for concurrent hearings to shorten the time between admission of patients to the Vermont State Hospital and the administration of involuntary psychiatric medication on a non-emergency basis to those who refuse to take the medication voluntarily, Michael said. The time frame from admission to medication is likely to remain as it is now, between sixty and ninety days on average.

In the circumstances, Michael explained, DMH has shifted its focus away from the first part of the process and toward the end, after medication has begun and patients are getting well enough to leave the State Hospital. Based on the experience of the past two years, he said, we can expect an average four-month length of stay after medication begins.

Act 114 involuntary medication can happen in hospitals other than VSH. No other hospitals, however, have developed involuntary medication protocols. What we are seeking is to start using involuntary medication orders for persons who are released from VSH on an order of nonhospitalization (ONH). This step was included in Act 114 and there are rules that were developed in 1998 to guide the process. DMH will begin use of this option at some points in the months ahead—but would seek to gain input from stakeholders and ensure that all understand the use of this aspect of the statute. At present only patients released from VSH would have such an order, and VSH would be the only designated hospital that would administer the medications.

Wendy Beinner explained that the rules for administering involuntary medications under Act 114 are meant to protect someone under a court order for involuntary medication. DMH developed the rules in collaboration with a whole host of advocates (Vermont Protection and Advocacy, Legal Aid, the Rules Committee, and others). Wendy passed around descriptions of two hypothetical patients on community commitments (orders of nonhospitalization) who are also under court orders for psychiatric medications and the circumstances in which they could be returned to the State Hospital for a brief period to keep their medication going. Michael added that these two scenarios would be applicable to a very small subset of adults and emphasized that DMH's preference would be to go through the process as infrequently as possible. Tom Simpatico, the Medical Director at VSH, expanded upon Michael's remarks with the observation that this process offers people who regularly stop medications and decompensate another way of staying in the community instead of coming back to VSH for possibly longer inpatient stays.

Standing Committee members raised several points about Act 114 in the general discussion that followed:

- The complexity of the process
- The coercion inherent in the process

- Discomfort on the part of community providers
- Perceived threats to relationships
- Exploration of alternatives before medicating people involuntarily
- The fact that some people do not know that they have a mental illness

The discussion ended with Wendy's reassurance that this process is really a last resort for a very few people (eighteen in 2007). Michael reinforced the observation about lack of insight into illness noting that most people who are medicated under Act 114 have psychotic disorders.

Wendy asked Standing Committee members to look at the materials she distributed and to let her hear their questions or other feedback. She would also like to hear any ideas on how to make the process more understandable for the general public.

May Agenda

Introductions
Reviewing agenda
Approving notes of last meeting
VSH Report: Terry Rowe
Re-designation of Counseling Service of Addison County (Melinda Murtaugh will invite representatives from CSAC to the meeting on May 12)
Final Report from the Pacific Health Policy Group and recommendations for designated agencies: Frank Reed
Durable Powers of Attorney and the Ulysses clause: Jessica Oski
Report on trauma: Marty Roberts
VSH training for psychiatric technicians